



ESARVHP

New Hampshire Emergency System
for Advance Registration of
Volunteer Healthcare Professionals

Veterinarian Registration

PLEASE PRINT CLEARLY

Information in RED is REQUIRED. PAGE 1

1. YOUR LICENSE INFORMATION EXACTLY as it appears on your professional license.

First Name _____

Middle Name _____

Last Name _____ Suffix _____

License # _____ State Issuing License _____ Exp. Date (mm/dd/yyyy) _____

2. CONTACT INFORMATION

Mailing Address _____

City _____ State/Zip _____ Country _____

Primary Phone _____ Alternate Phone _____

Email Address _____

3. CONSENTS AND PLEDGES

Do you consent to NH collecting, using and maintaining your personal information? ☐ YES ☐ NO

Do you pledge the information you have provided is correct? ☐ YES ☐ NO

Do you consent to allow the State of NH to perform a background check on you? ☐ YES ☐ NO

4. DEPLOYMENT PREFERENCES

Are you willing to work under the auspices of the Federal Government during a declared national public health emergency?

☐ YES ☐ NO

5. EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____

Emergency Contact Relationship ☐ Spouse ☐ Co-worker ☐ Relative ☐ Friend ☐ Other

Emergency Contact Home Phone _____ Work Phone _____

Email Address _____



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6. FOREIGN LANGUAGE/SIGNING SKILLS

Language(s) other than English you speak, read and/or write, or sign _____

Language Fluency ☐ Basic ☐ Conversational ☐ Fluent

American Sign Language Fluency ☐ Basic ☐ Conversational ☐ Fluent

7. DISASTER TRAINING

Type of specialized disaster training received _____

Date completed specialized disaster training (mm/dd/yyyy) _____

Training Institution that offered disaster training _____

Date specialized disaster training certification expires, if any (mm/dd/yyyy) _____

8. SPECIALIZED TRAINING YOU HAVE HAD

☐ ACLS ☐ ADLS ☐ BCLS/CPR ☐ BDLS ☐ CCRN ☐ CEN ☐ EMT ☐ EMT: B / I / P

☐ ENPC ☐ First Aid ☐ HAZ-MAT Decon ☐ HEICS ☐ ICS # _____ ☐ NIMS

☐ PALS ☐ Red Cross DSHR # _____ ☐ TNCC ☐ Wilderness First Responder

☐ Military Training (specify) _____

☐ Other Training (specify) _____



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9. OTHER VOLUNTEER ORGANIZATIONS YOU BELONG TO

- | | |
|--|---|
| <input type="checkbox"/> American Red Cross | <input type="checkbox"/> Civil Air Patrol |
| <input type="checkbox"/> Community Emergency Response Team | <input type="checkbox"/> Disaster Behavioral Health Response Team |
| <input type="checkbox"/> Disaster Medical Assistance | <input type="checkbox"/> Medical Response Corps |
| <input type="checkbox"/> Military Reserve | <input type="checkbox"/> National Nurse Response Team |
| <input type="checkbox"/> NH Public Health Network | <input type="checkbox"/> NH Strike Team |
| <input type="checkbox"/> State Citizens Corps Council | <input type="checkbox"/> Other (specify) _____ |

10. SPECIALTY If several specialties, enter one only.

*Enter information exactly as it appears on specialty certification/registration.

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)* _____

Organization that awarded specialty certification ☐ ABVP ☐ ABVT ☐ ACLAM ☐ ACPV ☐ ACT ☐ ACVA
☐ ACVB ☐ ACVCP ☐ ACVD ☐ ACVECC ☐ ACVIM
☐ ACVM ☐ ACVN ☐ ACVO

Area of specialty practice ☐ Diplomate ABMV ☐ Diplomate ABVT ☐ Diplomate ACLAM ☐ Diplomate ACPV
☐ Diplomate ACVA ☐ Diplomate ACVB ☐ Diplomate ACVCP
☐ Diplomate ACVD ☐ Diplomate ACVECC ☐ Diplomate ACVIM ☐ Diplomate ACVM
☐ Diplomate ACVN ☐ Diplomate ACVO

Specialty Certification Number _____ Expiration Date (mm/dd/yyyy) _____

11. PEER REFERENCE Required to assign ESAR-VHP credential level for those not practicing in a hospital.

Are you a private practitioner, i.e. not currently practicing in a hospital setting? ☐ Yes ☐ No If No, skip to Clinically Active



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Professional Peer's Name _____

Peer's Email _____

Peer's Phone (eg: 5555555555) _____

Peer's City, State _____

12. CLINICALLY ACTIVE Required to assign ESAR-VHP credential level if not currently practicing in a hospital setting.
* Where you practice in an outpatient or other non-hospital setting.

Clinical Supervisor's Name _____

Clinical Supervisor's Email _____

Clinical Supervisor's Phone (eg: 5555555555) _____

Facility Name* _____

Facility City, State* _____

13. DEA REGISTRATION *Enter information exactly as it appears on DEA registration.

First Name* _____

Middle Name or Initial* _____

Last Name* _____

Title(s)* _____

DEA Registration Number _____ Expiration Date (mm/dd/yyyy) _____

PRINT & MAIL ALL PAGES OF THIS FORM TO:

Curtis Metzger
Hospital Preparedness, Medical Reserve Corps, & ESAR-VHP Coordinator
NH HOMELAND SECURITY & EMERGENCY MANAGEMENT
33 Hazen Drive
Concord, NH 03305

THANK YOU FOR YOUR WILLINGNESS TO VOLUNTEER!